DOCUMENT RESUME

ED 439 383 CG 029 962

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TITLE	A.A. and Counseling: Conflict or Opportunity?
PUB DATE	1998-12-00
NOTE	11p.; In: "Relating in a Global Community." Proceedings of the International Conference on Counseling in the 21st Century (7th, Sydney, Australia, December 29-31, 1998); see CG 029 933.
PUB TYPE	Reports - Research (143) -- Speeches/Meeting Papers (150)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	*Alcohol Abuse; Alcoholism; Behavior Modification; *Compliance (Psychology); Counseling Effectiveness; Foreign Countries; Group Experience; Interpersonal Relationship; *Program Effectiveness
IDENTIFIERS	*Alcoholics Anonymous; Canada

ABSTRACT

The greatest focus in alcoholism treatment research today is matching client to treatment. Consistent with this research direction, this paper describes a survey completed by members of Alcoholic Anonymous (AA) regarding their assessment of AA as a treatment. It looks at the self-reported behaviors of AA members and compares these actions with program recommendations. In addition, it investigates the attitudes of AA members about other treatments and about AA itself, and seeks to identify areas of difficulty experienced when AA members address each of the 12 steps of the program. This paper reports that AA is a sufficient treatment unto itself for some people, but at least 23% of subjects felt that they required adjunctive treatment. Strong compliance with the program was demonstrated by responses to questions on whether or not subjects considered themselves alcoholics and whether or not they regularly attended meetings. Almost half the members had undergone the setback of drinking again, yet resumed their attempts at recovery. It notes the need to investigate the reasons why people in AA experience a high attrition rate. (Contains 34 references.) (JDM)

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ED 439 383

A.A AND COUNSELING: CONFLICT OR OPPORTUNITY?

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The greatest focus in alcoholism treatment research today is matching client to treatment. As if to define the decade of the '90s in terms of research emphasis, Project MATCH, the "largest, statistically most powerful, psychotherapy trial ever conducted" (Project MATCH Research Group [PMGR], 1996), was conceived and launched in 1989-90 (Azar, 1995). The mandate of this project was to identify "which kinds of individuals, with what kinds of alcohol problems, are likely to respond to what kinds of treatments by achieving which kinds of goals when delivered by which kinds of practitioners" (Institute of Medicine, 1990).

Consistent with this research direction, the present study surveys members of Alcoholics Anonymous (AA) regarding their assessment of AA as a treatment, a grassroots approach rarely found in the literature. To measure program compliance, it also records the self-reported behaviors of AA members and compares these actions with program recommendations. This research also investigates the attitudes of AA members about other treatments, about AA itself, and seeks to identify areas of difficulty experienced when AA members address each of the 12 steps of the program.

There is no single paradigm for alcoholism treatment (Morgenstern & Leeds, 1993). Treatment methodologies are generally based on the assumptions of one of four models of alcoholism: moral-volitional, personality, dispositional disease and the AA model, according to Miller and Kurtz (1994), who say that the AA model combines social, behavioral and cognitive components. AA has been described as "far and away the most frequently consulted source of help for drinking problems" (Miller & McCrady, 1993). According to Morgenstern and McCrady (1993), AA's therapeutic message "impacts the overwhelming majority" of alcoholics in the U.S. (p. 153).

Despite these comments about AA's influence, the United States National Academy of Science, Institute of Medicine, concluded in 1989 that "Alcoholics Anonymous, one of the most widely used approaches to recovery in the United States, remains one the least vigorously evaluated" (p. 197). It might also have been said that there is a paucity of data about the AA treatment as experienced by AA members themselves.

What is alcoholism?

Alcoholism has been described by Morse and Flavin (1992) as a chronic primary disease, often progressive and fatal, marked by continuous or periodic impaired control over alcohol consumption; preoccupation with alcohol; the use of alcohol in spite of adverse consequence; and distortions in thinking which includes denial of the condition. In 1957, the American Medical Association designated alcoholism as a disease.

What is A.A?

AA as such is not a treatment, but rather a social movement (Makela, 1993). However, AA does provide its members with rationales such as the one which is suggestive of a medical model, wherein alcoholism is held to be a progressive illness that is "a manifestation of an allergy; that the phenomenon of craving is limited to (alcoholics) and never occurs in the average temperate drinkers" (Alcoholics Anonymous, 1976). For this reason, AA considers abstinence as the only desirable treatment outcome (Vaillant & Hiller-Sturmhofel, 1996).

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The AA system employs a sponsor, or mentor, in their methodology. Kassel and Wagner (1993) describe the sponsor as an "important element of the AA approach ... an 'expert' senior member to whom initiates can turn for advice during the course of recovery" (p. 223). They also cite the Sponsor as one who facilitates the process of socialization (of the newcomer) to the group (p. 224). Le, Ingvarson and Page (1995) describe sponsorship as a source of continuous, personal help from those members who have made some progress in the program. Fagan (1986) demonstrates that, especially in the early stages of the process, sponsorship can contribute significantly toward recovery. On the other hand, Ogborne and Glaser (1985), point out that the profile of successful sponsors in AA are over 40, with a tendency to guilt, external locus of control, low conceptual level, a religious orientation, and suffering from existential anxiety, "hardly the characteristics of someone equipped to form a therapeutic bond" (p. 50).

The primary criticism of the AA program is from an empirical research standpoint. For example, Galaif and Sussman (1995) point out that correlational studies do not provide evidence to support a causal link between AA participation and sobriety (p. 164). Litrell (1991) says that only five to 13% of members will maintain an enduring relationship with AA. Furthermore, in studies where alcoholics are randomly assigned to different treatment, there is no evidence that AA works better. Vaillant & Hiller-Sturmhofel (1996) found that "about 2% of all alcoholics return to stable abstinence each year, with or without receiving treatment" (p. 157).

Le, Ingvarson and Page (1995) criticize the AA steps as revolving around themes of powerlessness, dependency, and humility. They adapt the steps to conform to counseling standards, and to change the orientation from those of removing character defects and personal shortcomings, as the AA program suggests, to developing strengths and abilities, as good counseling practice would prefer (p. 607).

Wheeler and Turner (1997) studied counselor's attitudes and experiences in working with alcoholics, as well as counselor's understanding of AA as a treatment. It was found that generic counselors tended not to feel competent working with patients with alcohol problems. As experience with client groups increased so did feelings of competence. This pattern continued, although to a lesser extent, with additional specialist training (p. 321). In their study knowledge of Alcoholics Anonymous was measured by asking the subjects (n = 91) what they knew about AA. 71% of counselors thought that AA attendance could be successfully combined with therapy. Wheeler and Turner conclude that counselors would benefit from a greater depth of understanding about the AA program (p. 324) and recommend more course content in alcohol counseling in professional training courses (p. 325).

Montgomery, Miller and Tonigan found that AA attendees were not different from nonattendees when compared by pretreatment characteristics (1994). On the other hand, the higher the degree of involvement with AA the better were predicted outcomes (p. 241). Montgomery et al. noted that their research was conducted in a residential treatment program "for which AA was a strong guiding philosophy", as opposed to AA itself (p. 244). Montgomery et al. concluded that those who study AA based on outcomes should not limit themselves to only measuring attendance at meetings, but also the extent to which individuals are applying the 12 steps of AA (p. 245).

Brown (1995) points out that the AA program has two independent parts, neither of which has therapeutic power without the other. The first of these two parts is the introduction to the program, including the literature, meetings and AA fellowship, which has as its purpose the achievement of ***sobriety***. The second part involves working the steps and has as its purpose the achievement of ***recovery*** (p. 69). According to Brown, sponsorship is the bridge between sobriety and recovery, and therefore has the power of success or failure, and "the sponsor represents the closest counterpart to the therapist" (p. 70). For Brown, distinguishing between sobriety and recovery in the use of the AA program is important, as is the selection of a sponsor (p. 79).

Other groups which use AA as their model have proliferated since the first one, Al-Anon, was started to address problems unique to the family of AA members in 1951 (Room & Greenfield, 1993). According to a 1990 interview survey (N = 2,058), 13.3% of the adult population of the U.S. have attended some form of 12-step meeting, whether alcohol-related or not (p. 555). Room and Greenfield make a long list of groups, with diverse purposes, which model their meeting format to some extent or other on the basis of AA. Despite this proliferation, AA still accounts for the majority of 12-step attendance (p. 561). Johnson and Chappel (1994) claim that more than 150 parallel groups have sprung from the AA model. Research by Room and Greenfield (1993) shows that 9 % of the adult U.S. population have attended at least one AA meeting at some time, and 3.6% have done so in the past year.

In the Project MATCH study referred to earlier, subjects (N = 1,726), taken from two different populations (outpatients and aftercare patients) were randomly assigned to three treatment methodologies: Cognitive-Behavioral Therapy (CBT), Motivational Enhancement Therapy (MET), and Twelve-Step Facilitation Therapy (TSF). The TSF Therapy is spiritually based, and has as its objective a fostering of acceptance of the disease of alcoholism, encouraging commitment to participate in the AA program, and beginning to work the 12 steps, (p. 13). Nowinski (1996) elaborates on this therapy by describing it as "philosophically and pragmatically compatible with the 12 steps of AA" (p. 39). Nonetheless, the Project MATCH Research Group emphasize that TSF is individually delivered, and in this respect departs sharply from the AA program (p. 24). On the basis of the foregoing description, Project MATCH claims to be "the first demonstration in a randomized clinical trial, controlling for other treatment factors, of comparable outcomes from a 12-step-based approach and other treatment methods" (p. 24). Project MATCH made the following conclusions:

> The findings suggest that psychiatric severity should be considered when assigning clients to outpatient therapies. The lack of other robust matching effects suggests that, aside from psychiatric severity, *providers need not take these client characteristics into account when triaging clients to one or the other of these three individually delivered treatment approaches*, despite their different treatment philosophies (emphasis added) (p. 7).

Methodology

Several researchers have noted the difficulty of applying ideal research methodologies and

procedures in the field of alcoholism (Miller & Kurtz, 1994; Nowinski, 1993) One difficulty is in locating subjects (Tonigan & Hiller-Sturmhofel, 1994; Page, 1986; Royce, 1989). Another lies in the ethical considerations and need for maintaining anonymity (McMcrady, 1993; Bradley, 1988).

Instrument

Based on reviews of the literature, the current study employed a 23-item questionnaire designed by the researcher. All respondents were self-described members of Alcoholics Anonymous, all resident in British Columbia, Canada. The questionnaire focused on knowledge about the AA program and belief in its efficacy. It also asked about other treatments, frequency of meeting attendance, adherence to AA suggestions about sponsorship and home meetings, likes and dislikes about AA, step difficulty, demographic information, and provided room for other comments. Ten questions were multiple choice, six were yes or no, and four were fill-in-the-blanks. Three questions were open-ended because of their usefulness in an otherwise quantitative study (Glesne & Webb, 1993).

Respondents

A total of 113 respondents were obtained by attending 22 closed meetings of AA as well as one AA convention and asking attendees to complete the questionnaire (the researcher qualifies as a member of AA). Subjects were solicited prior to and immediately following meetings. Some subjects claimed time constraints, in which case a stamped, addressed envelope was provided. More than half (58%) of all responses were obtained by mail. Of the 65 stamped envelopes provided to participants, 59 were received, yielding a response rate of 90.8%.

Pilot Study

For purposes of assessing armchair validity and internal consistency, Masters level students at University of Victoria as well as AA members tested the questionnaire. As a result of their responses and suggestions, appropriate modifications were made. There were five questions to measure knowledge of the AA program, each of them intended to measure different aspects of AA, including its main purpose, one of its steps, its group policy, one of its traditions, and the cost of membership. It was known from the results of the pilot questionnaires that the general academic population yielded correct answers little different from chance. It was also known that these same questions, when asked of members of AA, would probably result in very high scores. When this became apparent from the pilot studies, it was concluded that knowledge about AA can be considered an esoteric subject, that is: well-known to few and little known to others, in spite of the fact that as Chappel records (1993), "there is no dogma, theology or creed to learn" in the AA program. In all cases, AA literature is the final authority as to the correctness of answers to the questions.

Results

Data from the questionnaire were coded and analyzed using appropriate calculations. Frequencies, percentages and measures of central tendency were computed and displayed in tabular form.

Knowledge of the AA Program

The responses to questions one through five, which queried knowledge of the steps, membership charge, the primary purpose of AA, its group format and policy on closed meetings yielded a combined 549 correct answers (97.2%) out of a possible 565.

Ratings of alcoholism treatment effectiveness showed a preference for AA itself (46%), a combination of counseling and AA (33.6%), followed by a combination of counseling, AA, and a family doctor (14.2%). All 113 participants responded to this question, and all other combinations of treatments received little support.

In a later question, participants were asked to ***rank order,*** as opposed to ***rate***, treatments for alcoholism. AA received 101 of the highest ranking, professional counseling dominated the second ranking, with treatment by a family doctor and others, which were specified, far down in the rank order.

Duration of continuous sobriety was reported as less than one year, 21.2%; one to five years, 38.9%; five to 10 years, 12.4%; 10 to 20 years, 15%; and more than 20 years, 12.4%.

When AA respondents were asked about step difficulty, they rated Step Four as most difficult (15.9%), closely followed by Steps Six (14.2%) and Seven (8.9%). No other steps stood out as presenting difficulty to program members.

Discussion and Summary

This research adheres to the primary belief: "if you want to know about AA, ask the people who are in the program." To measure knowledge of the AA program a series of statements was taken from AA literature and adapted into questions. These esoteric questions are a valid and reliable instrument to discriminate members of Alcoholics Anonymous from any other population.

Being capable of answering questions about AA is one thing, and applying the tenets of the program into their life is another. Taken individually, the answers to these questions have armchair validity about program commitment by the AA subjects polled. Collectively, the answers are a powerful indicator of such compliance.

As to the subject of belief in the efficacy of the program, this was measured by the question that rated treatments (Question 7), and subsequently confirmed by the slightly differently worded Question 10, which asked for a rank order of the same treatments. Additional information can be garnered from Questions 19 and 20, which relate to previous treatment and inquire about current treatment, respectively. Although there is not every confidence that the trend between the two questions, showing less subjects employing another treatment now compared to prior to becoming a member of AA, the trend is nonetheless a significant one. The direction would at least suggest that AA is a sufficient treatment unto itself *for some people.* The other side of the coin is the obvious fact that at least 23% of subjects feel that they require adjunctive treatment for alcoholism. Whereas AA may constitute a powerful treatment methodology, one that dominates alcoholism treatment, the search for alternative therapies is justified and appropriate.

AA members evidence a high degree of compliance with the AA program according to their reported behaviors. Question 9, which measured meeting attendance frequency, showed that

93.8% of all members polled attend at least one meeting a month, while two-thirds attend more than once a week. These results should be placed in the context of individual clients voluntarily taking the time to administer, in effect, their own treatment. Another compelling piece of evidence lies in the responses to Question 11, which related to having a home group, as is recommended by the AA program. 85.8% reported program compliance with such behavior.

Of course there is a difference between attending a meeting and joining a home group. Belonging to a group is a recommended activity of the AA program, and as such it is a reliable and valid measure of program compliance. Question 12 concerned itself with sponsorship; AA recommends that members have a sponsor. In actual AA practice, selecting a sponsor is something of a ritual. By tradition, the sponsee approaches the sponsor and requests that a relationship be established. It is the position of this thesis that having a sponsor is a strong indicator of program compliance by members.

The response to Question 13 (are you an alcoholic?) can also be interpreted as compliance with and belief in the program. AA promotes the view that alcoholism is a "malady". Furthermore, the AA literature insists that treatment and abstinence from alcohol are life-long necessities (once an alcoholic, always an alcoholic). Many researchers have pointed out the fact that the AA position on the medical model also serves to alleviate shame for its members.

The results of Question 13 "Do you consider yourself to be an alcoholic?", are remarkable in that even though an alternative to "yes" or "no" was provided in the questionnaire (namely "sometimes"), not a single subject selected it. The "sometimes" alternative was a reasonable one, and frankly was designed to capture those respondents who even occasionally entertained doubt about their condition. However, the results of this question was 100% yes, which is consistent with the AA credo, and which corroborates evidence of strong compliance with the program.

The two most astonishing conclusions in current alcoholism research today are those of Project MATCH, which found that it did not matter which of three treatments were assigned, in the absence of serious psychopathology, the results were the same. The other is the recent findings of Vaillant and Hiller-Sturmhofel that "about 2% of alcoholics return to stable abstinence each year, with or without receiving treatment" (1996, p. 157).

Like any consumer feedback, the information from these questions can be applied to the research on treatment-client matching. Any treatment program existent, or designed in the future, should include the information about what people like and do not like. If the research history is clear on anything, it is clear that client involvement and commitment should be encouraged in any alcoholism treatment.

One of the strongest expressed likes of AA members fall into the category of Social Aspects (see Table 14). These are generally characterized by such words and phrases as "fellowship", "the people", "the meetings", "acceptance", etc. Almost two-thirds of respondents chose such social terms. The balance almost all selected functional aspects, such as "the steps", "the traditions", "it works", etc.

On the other hand, when asked about dislikes, the majority either had no dislikes, or no opinion. Of those who did name a dislike, the majority of these were either smoking or the coffee, both of which are avoidable.

Question 17, which related to step difficulty, pinpoints a vulnerability of the AA program. Almost any veteran of the program could probably have predicted that Step Four is a difficult step. This step ("Made a searching and fearless moral inventory of ourselves") calls for insight beyond the experiences of most newcomers. Although the Big Book does describe this step, and in fact provides a fairly detailed description of how to proceed, in the final analysis it is up to the individual to interpret. It is not surprising that books have been written on this subject alone. Step Four is a complicated one.

What is surprising is that right next to Step Four in reported difficulty is Step 6 ("Were entirely ready to have God remove all these defects of character"). Step Four received 18 mentions, while Step Six received 16. I personally know of no special arrangements, made by AA or any of its offshoots, that concentrates on helping clients comprehend Step 6. This could be a major finding in AA research. Step Seven, even more obscure than its predecessor, also attracted a substantial number of votes as the most difficult, with 10. The combination of the two steps are named by more than one third of those polled, outdistancing Step Four in reported difficulty. It is likely that the reported difficulty with steps Six and Seven are the result of a perceived threat to the identity of the person negotiating these two steps. The two steps go together, and read as follows:

6. *Were entirely ready to have God remove all these defects of character* (AAWS, p. 57).
7. *Humbly asked Him to remove our shortcomings* (AAWS, p. 57)..

The main stumbling block seems centered on the comprehensive word "all" in describing the defects of character to be removed. Some members reason that they would like to hang on to some part of themselves, even if that is a "defective" part. Thus it may be that fear of losing one's identity is at the root of the "difficulty" of these steps.

Unfortunately, the nature of researching a subject such as AA, with its emphasis on anonymity, is difficult. At the same time, within the framework of these difficulties, the researcher has been attending AA meetings for more than 22 years, and has the advantage of being able to attend closed meetings. Open meetings, which are the subject of most research on AA, are different from closed meetings in that the attendees may or may not be members of AA. This researcher has observed a noticeable difference in the intensity between the two types of meeting. By definition, also, Open meetings may not be representative of AA meetings, depending upon the number of AA members present.

The results of this study show that almost half the members (48.7%) had undergone the setback of drinking again, yet resumed their attempts at recovery. Much may be learned by comparing the results of a similar question asked of those undergoing therapies different from AA. Implicit in this and other alcoholism treatment research is the matter of high attrition as experienced by AA. According to virtually every study on the subject, there is a steady decline in membership when measured by length of sobriety. Obviously some people go back to drinking, some die, and some stay sober without attending AA. A tantalizing research subject is, "What

happens to AA members over time? What happens to those who stop attending AA meetings?" If, as AA maintains, AA is a program for living, study people living the program but not attending AA: in other words, AA dropouts. These people would fall into two categories, those who abstain, and those who continue to drink socially. How might these two populations compare to each other in terms of "degree of alcoholism", such as could be implied from the Johns Hopkins 20 Question Test? Research in this direction would potentially provide a wealth of implications for alcoholism treatment, and would tend to sustain or refute the AA position that "once an alcoholic, always an alcoholic". Research into this series of questions will be the subject of my doctoral dissertation.

This study is probably generalizable to Canada and the U. S. Confidence in the results flow from the similar demographic findings to those of the AA Survey of Canadian and American subjects. If there is a shortcoming to this study it lies in the methodology, for participant selection was more or less by convenience, and not random. These results will be compared to a duplicate study to be undertaken in Australia.

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